Skilled Nursing Facility Quality Assurance Fee – (FY09) Payment Invoice for August 1, 2009 to August 31, 2009

Department of Health Care Services Accounting Section/Cashiers Unit Mail Stop 1101 1501 Capitol Ave., Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415

OSHPD Number:

NPI 1	Number:
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Please add OSHPD and NPI number along with facility's name address and contact information when making a payment.

Due Date: 10/31/2009

Total Remitted: \$_____

		Object	Agency	BLK		Agency	PCA		
NPI	Index	Detail	Object	2211	Source	Source	1011	FFY	Fund
	5650	000	00	Н	125600	31	85214	A09	0001
Total Resident Days		Multiply by	\$11.16 = Tota	al Amount	Due				
Original Signature			_ Date						
Please Print Name			Contact Pl	none no.			E-mail		

(Please remit the total amount along with this payment Invoice by due date above)
PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but

is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance

Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due - Multiply the Facility's Total Resident Days by \$11.16 and enter that amount in the space provided for the Total

Amount Due.

Total Remitted - Enter the amount of the check or money order you are sending with this invoice. This amount should be the

same amount as the Total Amount Due.

Original Signature - Sign here in the space provided. Please use ink.

Date - Enter the date you completed this form.

Contact Phone No. - Enter your area code and daytime phone number and email address.

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Skilled Nursing Facility Quality Assurance Fee – (FY09) Payment Invoice for September 1, 2009 to September 30, 2009

Department of Health Care Services Accounting Section/Cashiers Unit Mail Stop 1101 1501 Capitol Ave., Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415

OSHPD Number:

Please add OSHPD and NPI number along with facility's name	
address and contact information when making a payment.	

NPI Number:

Due Date: 10/31/2009

Total Remitted: \$_____

		Object	Agency	BLK		Agency	PCA			
NPI	Index	Detail	Object	2211	Source	Source	1 011	FFY	Fund	
	5650	000	00	Н	125600	31	85214	A09	0001	
Total Resident Days	N	Iultiply by \$	11.16 = Tota	l Amount l	Due					
Original Signature			Date							
Please Print Name			Contact Ph	one no			E-mail_			

(Please remit the total amount along with this payment Invoice by due date above) PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but

is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance

Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due - Multiply the Facility's Total Resident Days by \$11.16 and enter that amount in the space provided for the Total

Amount Due.

Total Remitted - Enter the amount of the check or money order you are sending with this invoice. This amount should be the

same amount as the Total Amount Due.

Original Signature - Sign here in the space provided. Please use ink.

Date - Enter the date you completed this form.

Contact Phone No. - Enter your area code and daytime phone number and email address.

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Skilled Nursing Facility Quality Assurance Fee – (FY09) Payment Invoice for October 1, 2009 to October 31, 2009

Department of Health Care Services Accounting Section/Cashiers Unit Mail Stop 1101 1501 Capitol Ave., Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415

OSHPD Number:

NPI Number:

Please add OSHPD and NPI number along with facility's name address and contact information when making a payment.

Due Date: 11/30/2009

Total Remitted: \$_____

		Object	Agency	BLK		Agency	PCA			
NPI	Index	Detail	Object	2211	Source	Source	1 011	FFY	Fund	
	5650	000	00	Н	125600	31	85214	A09	0001	
Total Resident Days	N	Iultiply by \$	11.16 = Tota	l Amount D	Oue					
Original Signature			Date							
Please Print Name			Contact Ph	one no.			E-mail			

(Please remit the total amount along with this payment Invoice by due date above) PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but

is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance

Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due -

Amount Due.

Multiply the Facility's Total Resident Days by \$11.16 and enter that amount in the space provided for the Total

Total Remitted - Enter the amount of the check or money order you are sending with this invoice/ This amount should be the

same amount as the Total Amount Due.

Original Signature - Sign here in space provided. Please use ink.

Date - Enter the date you completed this form.

Contact Phone No. - Enter your area code and daytime phone number and email address.

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Skilled Nursing Facility Quality Assurance Fee – (FY09) Payment Invoice for November 1, 2009 to November 30, 2009

Department of Health Care Services
Accounting Section/Cashiers Unit Mail Stop 1101
1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

OSHPD Number:

NPI Number	
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Please add OSHPD and NPI number along with facility's name address and contact information when making a payment.

Due Date: 12/31/2009

Total Remitted: \$

		Object	Agency	BLK		Agency	PCA		
NPI	Index	Detail	Object		Source	Source		FFY	Fund
	5650	000	00	Н	125600	31	85214	A09	0001
Total Resident Days		Multiply by	\$11.16 = Tota	al Amount	Due				
Original Signature			_ Date						
Please Print Name			Contact Pl	hone no			E-mail		

(Please remit the total amount along with this payment Invoice by due date above) PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE - DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days -Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance

Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due -Multiply the Facility's Total Resident Days by \$11.16 and enter that amount in the space provided for the Total

Amount Due.

Total Remitted -Enter the amount of the check or money order you are sending with this invoice. This amount should be the

same amount as the Total Amount Due.

Original Signature -Sign here in the space provided. Please use ink.

Date -Enter the date you completed this form.

Contact Phone No. -Enter your area code and daytime phone number and email address.

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Skilled Nursing Facility Quality Assurance Fee – (FY09) Payment Invoice for December 1, 2009 to December 31, 2009

Department of Hea Accounting Section 1501 Capitol Ave. P.O. Box 997415 Sacramento, CA 9	n/Cashiers Unit N , Suite 71.2048		1			OS	HPD Numbe	er:	
Please add OS			_	-	ame addre	ess NP	I Number:		
and contact inf	formation who	en making	a payment.			.Du	ne Date: 1/31	/2010	
						Tot	al Remitted:	\$	
NPI	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	Н	125600	31	85214	A09	0001
otal Resident Days	N	Multiply by \$	11.16 = Tota	l Amount	Due			-	
Original Signature			Date						
Please Print Name			Contact Ph	one no.			E-mail_		

Payment Invoice Instructions

Total Resident Days -	Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.
Total Amount Due -	Multiply the Facility's Total Resident Days by \$11.16 and enter that amount in the space provided for the Total Amount Due.
Total Remitted -	Enter the amount of the check or money order you are sending with this invoice. This amount should be the same amount as the Total Amount Due.
Original Signature -	Sign here in the space provided. Please use ink.
Date -	Enter the date you completed this form.
Contact Phone No	Enter your area code and daytime phone number and email address.
D	

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Skilled Nursing Facility Quality Assurance Fee – (FY09) Payment Invoice for January 1, 2010 to January 31, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit Mail Stop 1101
1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

OSHPD Number:

Please add OSHPD and NPI number along with facility's name address	NPI Number:
and contact information when making a payment.	

Due Date: 2/30/2010

Total Remitted: \$____

		Object	Agency	BLK		Agency	PCA			
NPI	Index	Detail	Object		Source	Source	1 011	FFY	Fund	
	5650	000	00	Н	125600	31	85214	A09	0001	
Total Resident Days	N	fultiply by \$	11.16 = Total	Amount I	Oue					
Original Signature			Date							
Please Print Name			Contact Pho	one no.			E-mail			

(Please remit the total amount along with this payment Invoice by due date above) PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due - Amount Due.

Multiply the Facility's Total Resident Days by \$11.16 and enter that amount in the space provided for the Total

Total Remitted -

Enter the amount of the check or money order you are sending with this invoice. This amount should be the

same amount as the Total Amount Due.

Original Signature - Sign here in space provided. Please use ink.

Date - Enter the date you completed this form.

Contact Phone No. - Enter your area code and daytime phone number and email address.

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – (FY09) Payment Invoice for February 1, 2010 to February 28, 2010

Department of Health Care Services 15 P.0 Sa

Accounting Section/Cash 1501 Capitol Avenue, Su P.O. Box 997415 Sacramento, CA 95899-	Office of Statewide Health Planning and Development Number:											
						Nation	nal Provider l	dentifier: _				
						Due Date: 3/31/2010						
						Amou	nt Remitted:	\$				
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund			
	5650	000	00	Н	125600	31	85214	A09	0001			
Total Resident Days		Multiply	by \$11.16 =	Amount D	ue							
Original Signature			Date									
Print Name			Phone Numb	er		E-Mai	1					
Payment Invoice Inst		SE SUBMIT	THE ENTIRE	E PAYMEN	T INVOICE	– DO NOT C	CUT IN HAI	.F				
Total Resident Days -	numbe Bed H	er of days in old Days, M		nt resides a or-Service,	nt the skilled Medi-Cal M	nursing facil	lity. This ir e, Medicare	ncludes, bu , Health M	nt days are the t is not limited laintenance			

Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due -Multiply the Total Resident Days by \$11.16 and enter that amount in the space provided for the Amount

Due.

Amount Remitted -Enter the amount of the check or money order you are sending with this payment invoice. This amount

should be the same amount as the Amount Due.

Original Signature -Sign in the space provided. Please use ink.

Date -Enter the date you completed this payment invoice.

Phone Number/E-Mail -Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – (FY09) Payment Invoice for March 1, 2010 to March 31, 2010

Payment Invoice In		SE SUBMIT	THE ENTIRE	E PAYMEN	T INVOICE	– DO NOT C	UT IN HAL	F				
Print Name Phone Number							E-Mail					
Original Signature _			Date									
Total Resident Days_		Multiply	by \$11.16 =	Amount D	ue							
	5650	000	00	Н	125600	31	85214	A09	000			
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund			
						Amou	nt Remitted:	\$				
						Due Date: 4/30/2010						
						Nation	al Provider I	dentifier: _				
Accounting Section/Ca 1501 Capitol Avenue, S P.O. Box 997415 Sacramento, CA 95899	Suite 71.2048		Office of Statewide Health Planning and Development Number:									

Pa

Enter the Total Resident Days for the month that is listed on the payment invoice. Resident days are the Total Resident Days -

> number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance

Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due -Multiply the Total Resident Days by \$11.16 and enter that amount in the space provided for the Amount

Due.

Amount Remitted -Enter the amount of the check or money order you are sending with this payment invoice. This amount

should be the same amount as the Amount Due.

Original Signature -Sign in the space provided. Please use ink.

Date -Enter the date you completed this payment invoice.

Phone Number/E-Mail -Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – (FY09) Payment Invoice for April 1, 2010 to April 30, 2010

Dε A 15 P.

Accounting Section/Cashiers Unit, Mail Stop 1101 1501 Capitol Avenue, Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415							Office of Statewide Health Planning and Development Number:					
						National Provider Identifier:						
				Due Date: 5/31/2010								
						Amou	nt Remitted:	\$				
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund			
	5650	000	00	Н	125600	31	85214	A09	0001			
Total Resident Days		Multiply	by \$11.16 =	Amount D	ue							
Original Signature			Date									
Print Name			Phone Numb	er		E-Mai	I					
Payment Invoice Inst		SE SUBMIT	THE ENTIRE	E PAYMEN	T INVOICE	– DO NOT C	UT IN HAL	Æ				
Total Resident Days -	numbe Bed H	er of days in old Days, M		nt resides a or-Service,	t the skilled Medi-Cal M	nursing facil	ity. This ir e, Medicare	icludes, bu , Health M	nt days are the t is not limited faintenance			
4	3.6.1.1	1 4 77 3	D 11 . D	1 0111	c 1		.1	.1.10				

Pa

Amount Due -Multiply the Total Resident Days by \$11.16 and enter that amount in the space provided for the Amount

Due.

Amount Remitted -Enter the amount of the check or money order you are sending with this payment invoice. This amount

should be the same amount as the Amount Due.

Original Signature -Sign in the space provided. Please use ink.

Date -Enter the date you completed this payment invoice.

Phone Number/E-Mail -Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – (FY 10) Payment Invoice for May 1 to May 31, 2010

Accounting Section/Cashi 1501 Capitol Avenue, Suit P.O. Box 997415	Iail Stop 1101	Office of Statewide Health Planning and Development Number:									
Sacramento, CA 95899-7-	415		Nation	nal Provider I	dentifier (N	PI):					
Please add OSHPD and contact information				vate: 6/30/10							
						Amou	nt Remitted:	\$			
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund		
	5650	000	00	Н	125600	31	85214	A09	0001		
Total Resident Days		Multiply	by \$11.16 =	Amount D	ue						
Original Signature			Date _								
Print Name			Phone	Number		E-Mail					
Payment Invoice Instr		SE SUBMIT	THE ENTIRE	E PAYMEN	T INVOICE	– DO NOT C	UT IN HAI	Æ			
Total Resident Days -	numbe Bed H	er of days in old Days, M		nt resides a or-Service	at the skilled , Medi-Cal M	nursing facil	lity. This ir e, Medicare	ncludes, bu , Health M	nt days are the t is not limited to aintenance		
Amount Due -	Multip Due.	oly the <i>Total</i>	Resident Day	es by \$11.1	6 and enter tl	hat amount is	n the space	provided f	or the Amount		
Amount Remitted -			of the check of amount as the	•	•	sending with	this payme	nt invoice.	This amount		
Original Signature -	Sign in	n the space p	rovided. Plea	ase use ink							
Date -	Enter t	the date you	completed the	is payment	invoice.						
Phone Number/E-Mail	- Enter	your area co	de, daytime p	hone numb	er, and E-Ma	ail address.					
Payment invoices are av	vailable or	nline at: http	://www.dhcs.	ca.gov/pro	vgovpart/Pag	es/OualitvA	ssuranceFe	e.aspx.			

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – (FY 10) Payment Invoice for June 1 to June 30, 2010

Department of Health Car Accounting Section/Cashi 1501 Capitol Avenue, Sui P.O. Box 997415		Office of Statewide Health Planning and Development Number:									
Sacramento, CA 95899-7		Nation	al Provider l	Identifier (N	PI):						
Please add OSHPD and contact information			ame addres	address Due Date: 7/31/10							
						Amou	nt Remitted:	\$			
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund		
	5650	000	00	Н	125600	31	85214	A09	0001		
Total Resident Days		Multiply	by \$11.16 =	Amount D	ue						
Original Signature			Date _								
Print Name			Phone	Number		E-Mail					
Payment Invoice Instr		SE SUBMIT	THE ENTIRE	E PAYMEN	T INVOICE	– DO NOT C	UT IN HAI	LF			
Total Resident Days -	numbe Bed H	er of days in old Days, M		nt resides a or-Service,	at the skilled , Medi-Cal N	nursing facil	lity. This ir e, Medicare	ncludes, bu , Health M	nt days are the t is not limited to laintenance		
Amount Due -	Multip Due.	oly the <i>Total</i>	Resident Day	s by \$11.1	6 and enter tl	hat amount i	n the space	provided f	or the Amount		
Amount Remitted -			of the check of amount as the	-	-	sending with	this payme	nt invoice.	This amount		
Original Signature -	Sign in	n the space p	rovided. Plea	ase use ink							
Date -	Enter t	the date you	completed the	is payment	invoice.						
Phone Number/E-Mail	- Enter	your area co	de, daytime p	hone numb	er, and E-Ma	ail address.					
Payment invoices are a	vailable oi	nline at: <u>http</u>	://www.dhcs.	ca.gov/pro	vgovpart/Pag	ges/QualityA	ssuranceFe	e.aspx.			

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – (FY 10) Payment Invoice for July 1 to July 31, 2010

Accounting Section/Cashid 1501 Capitol Avenue, Suit P.O. Box 997415	Iail Stop 1101	Office of Statewide Health Planning and Development Number:							
Sacramento, CA 95899-74	415					Nation	al Provider I	dentifier (N	PI):
Please add OSHPD and contact informa				ate: 8/31/10					
						Amou	nt Remitted:	\$	
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	Н	125600	31	85214	A09	0001
Total Resident Days		Multiply	by \$11.16 =	Amount D	ue				
Original Signature			Date						
Print Name			Phone	Number		1	E-Mail		
Payment Invoice Instr		SE SUBMIT	THE ENTIRE	PAYMEN	T INVOICE	– DO NOT C	UT IN HAL	F	
Total Resident Days -	numbe Bed H	er of days in old Days, M		nt resides a or-Service,	at the skilled , Medi-Cal M	nursing facil	ity. This in e, Medicare	cludes, bu , Health M	nt days are the t is not limited to aintenance
Amount Due -	Multip Due.	oly the <i>Total</i>	Resident Day	s by \$11.1	6 and enter tl	hat amount is	n the space	provided fo	or the Amount
Amount Remitted -			of the check of amount as th	•	•	ending with	this payme	nt invoice.	This amount
Original Signature -	Sign in	n the space p	rovided. Plea	ise use ink	•				
Date -	Enter t	the date you	completed thi	is payment	invoice.				
Phone Number/E-Mail -	- Enter	your area co	de, daytime pl	hone numb	er, and E-Ma	ail address.			
Payment invoices are av	ailable or	nline at: http	://www.dhcs.o	ca.gov/pro	vgovpart/Pag	es/OualitvA	ssuranceFe	e.aspx.	